

No. 2
-12-45
-17-39
X47070

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED APR 9 1947

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. **8268**
Registrar's No. **18**

Registration District No. **61** Primary Registration District No. **4107**

1. PLACE OF DEATH:
(a) County **CODAR**
(b) City or town **ENCLARADO SPRINGS, MO.**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **1**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **HOMB**
In this community **WIZETIME** (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State **Missouri** (b) County **Seclair 93**
(c) City or town **Rural**
(If outside city or town limits, write "RURAL")
(d) Street No. **Washington Trf**
(If rural, give location)
(e) Citizen of foreign country? **no** (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME **LAWRENCE GOODWIN**
(b) If veteran, name war **---**
(c) Social Security No. **---**

MEDICAL CERTIFICATION
20. DATE OF DEATH: Month **March** day **9**
year **1947** hour **6** minute **30 PM** M.
21. I hereby certify that I attended the deceased from **7 March**
1947 to **9 March 1947**
that I last saw him alive on **9 March 1947**
and that death occurred on the date and hour stated above.

4. Sex **MALE** 5. Color or race **WHITE**
6. (a) Single, widowed, married, divorced **WIDOWER**
6. (b) Name of husband or wife **---**
6. (c) Age of husband or wife if alive **---** years
7. Birth date of deceased **July 10 1875**
(Month) (Day) (Year)

Immediate cause of death **LOBAR PNEUMONIA** Duration **2 WEEKS**
LEFT + RIGHT LOWER LOBES

8. AGE: Years **71** Months **8** Days **4**
If less than one day hr. min.

Other conditions **FROZEN FEET** Duration **2 WEEKS**
(Include pregnancy within 3 months of death)
Major findings: Of operations **NONE**
Of autopsy **NONE**

9. Birthplace **Seclair Mo**
(City, town, or county) (State or foreign country)
10. Usual occupation **Farmer**

PHYSICIAN **---**
Underline the cause to which death should be charged statistically.

MOTHER FATHER

11. Industry or business
12. Name **Joseph Goodwin**
13. Birthplace **Mo**
(City, town, or county) (State or foreign country)
14. Maiden name **Eveline Nicholas**
15. Birthplace **Mo**
(City, town, or county) (State or foreign country)

16. (a) Informant **Eva Goodwin**
(b) Address **Rt. 1, Seclar, Mo**
17. (a) **Burial** (b) Date thereof **3-12-1947**
(Burial, cremation, or removal) (Month) (Day) (Year)
(c) Place: burial or cremation **Cath. Cemetery**
18. (a) Signature of funeral director **Edw. Carther**
(b) Address **Edw. Springs, Mo**
19. (a) **3/13/47** (b) **J. C. Brannan**
(Date received local registrar) (Registrar's signature)

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
While at work? (Specify type of place) (e) Means of injury **---**
23. Signature **Norman L. Clayson** (M. D. or other) **MD**
Address **Edw. Springs, Mo** Date signed **12 Mar 47**

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

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RECEIVED
District Health Officer No. 71
District File Number 2-17-408
District File Number 4-8-47
Date Filed

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed, *Floyd C. Parakev*
Licensed Embalmer No. *4419*
P. O. Address *C. Donald Springs*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.